

<b>Case Number:</b>	CM15-0063925		
<b>Date Assigned:</b>	04/09/2015	<b>Date of Injury:</b>	03/29/2004
<b>Decision Date:</b>	06/05/2015	<b>UR Denial Date:</b>	03/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/03/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials: State(s) of Licensure: California, Washington Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 64 year old female who sustained an industrial injury to the neck and right upper extremity on 03/29/2004. Previous treatment included transcutaneous electrical nerve stimulator unit, heat/ice and medications. In a PR-2 dated 02/16/2015, the injured worker complained of pain to the neck with radiation into the right shoulder associated with right arm numbness and weakness and right hand paresthesia. The injured worker also complained of headaches. The physician noted that the injured worker had a history of colitis and chronic constipation and had recently been hospitalized for a gastrointestinal disorder. Physical exam was remarkable for cervical spine with tenderness to palpation in the trapezius, restricted range of motion, motor strength 5/5 to bilateral upper extremities and decreased sensation at the C5-6 distribution. Current diagnoses included cervical spine degenerative disc disease, cervical disc displacement, cervical spine radiculopathy, anxiety and fatigue. The treatment plan included medications, a gastrointestinal consultation, TENS unit supplies, a psychiatry consultation, a rheumatology consultation and chiropractic therapy once a week for twelve weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Flexeril 10mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 63-66.

**Decision rationale:** California MTUS guidelines state muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. In this case, there was no documentation of palpable muscle spasm or spasticity upon examination. The medical necessity for a muscle relaxant has not been established in this case. Guidelines do not support long-term use of this medication. There was no frequency listed in the request. As such, the request is not medically necessary.

**Norco 10/325mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, the injured worker has continuously utilized Norco 10/325 mg since at least 07/2014. There was no documentation of a written consent or agreement for chronic use of an opioid. There was no evidence of objective functional improvement despite the ongoing use of this medication. Recent urine toxicology reports documenting evidence of patient compliance and nonaberrant behavior were not provided. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

**Ondansetron 4mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Ondansetron (Zofran).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Ondansetron, Antiemetic.

**Decision rationale:** The Official Disability Guidelines do not recommend ondansetron for nausea and vomiting secondary to chronic opioid use. It has been FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment and is FDA approved for acute gastroenteritis. The injured worker does not maintain a diagnosis of acute gastroenteritis. The medical necessity for the requested medication has not been established in this case. There is also no frequency listed in the request. As such, the request is not medically necessary.

**Voltaren gel 1% #5:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 111-1113.

**Decision rationale:** California MTUS Guidelines state the only FDA approved topical NSAID is diclofenac gel 1%, which is indicated for the relief of osteoarthritis pain. The injured worker does not maintain a diagnosis of osteoarthritis. In addition, topical diclofenac has not been evaluated for treatment of the spine, hip, or shoulder. The request as submitted failed to indicate the specific frequency of the medication. Given the above, the request is not medically necessary.

**Flector patch 1.3% #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 111-113.

**Decision rationale:** California MTUS Guidelines state the only FDA approved topical NSAID is diclofenac gel 1%, which is indicated for the relief of osteoarthritis pain. The injured worker does not maintain a diagnosis of osteoarthritis. In addition, topical diclofenac has not been evaluated for treatment of the spine, hip, or shoulder. The request as submitted failed to indicate the specific frequency of the medication. Given the above, the request is not medically necessary.

**Floranex #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pmed/18181732>.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Updated: 29 April 2015. U.S. National Library of Medicine.

**Decision rationale:** According to the U.S. National Library of Medicine, lactobacillus is a type of bacteria that is used for treating and preventing diarrhea. It is also used for treatment of general digestion problems. In this case, there was a lack of documentation identifying how the requested medication would provide an improved outcome for this injured worker. The medical necessity for the requested medication has not been established. There is no documentation of a general digestion problem or chronic diarrhea. The medical necessity has not been established. Therefore, the request is not medically appropriate at this time.

**Lorazepam 1mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s):  
24.

**Decision rationale:** California MTUS Guidelines do not recommend long-term use of benzodiazepines, because long-term efficacy is unproven and there is a risk of dependence. The injured worker does maintain a diagnosis of anxiety disorder. However, there was no recent psychological examination provided. There is no mention of functional improvement as a result of the ongoing use of this medication. There is also no frequency listed in the request. Given the above, the request is not medically necessary.